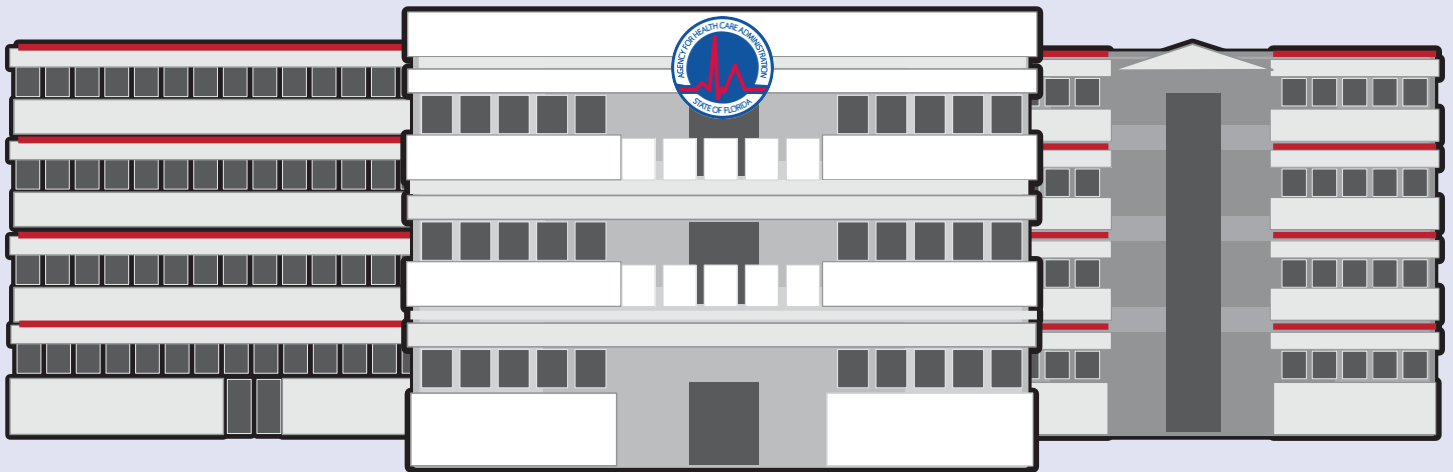


Agency for Health Care Administration

# Office of Inspector General



## Annual Report FY 2015-16







## **OUR MISSION**

Better Health Care for all Floridians.

## **OUR VISION**

A health care system that empowers consumers, that rewards personal responsibility and where patients, providers and payers work for better outcomes at the best price.

## **OUR VALUES**

**Accountability**– We are responsible, efficient and transparent.

**Fairness**– We treat people in a respectful, consistent and objective manner.

**Responsiveness**– We address people’s needs in a timely, effective, and courteous manner.

**Teamwork**– We collaborate and share our ideas.

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## A MESSAGE FROM THE INSPECTOR GENERAL



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

As a representative of the 125 members of the Agency for Health Care Administration's (AHCA) Office of Inspector General (OIG), I am proud to submit this summary report of our work and accomplishments during State Fiscal Year 2015- 2016. The OIG's mission is to provide a central point for the coordination of activities and duties that promote accountability, integrity, and efficiency in AHCA and the programs that AHCA administers. This important mission could not be accomplished without the dedication and hard work of the auditors, analysts, administrators, investigators, pharmacists, review specialists, medical professionals, support personnel, and managers who comprise the OIG and its four component units.

The AHCA OIG is one of the largest inspectors general offices in Florida government, dedicated to combating fraud, waste and program abuse and to improving the efficiency of AHCA programs. A majority of our OIG's resource allocation is dedicated to the oversight of Medicaid payments to medical service providers, a crucial role since Medicaid dollars represent a significant part of the State of Florida's budget and the Medicaid program serves the State's most vulnerable citizens. The remaining OIG resources, also critical to the State's health care governance function, ensure that employee misconduct is properly investigated, program audits and reviews are coordinated and accomplished, and that information held by AHCA is protected in accordance with state and federal privacy laws.

I hope this report provides useful information on the OIG's work this past fiscal year. While the OIG's intangible deterrent impact cannot be fully represented in an annual report, the text and graphics that follow provide some understanding of the costs recovered and avoided as a result of the OIG's efforts, the investigations conducted, and the audits and reviews completed to ensure that the Agency for Health Care Administration is prepared to meet the needs of the public which it serves.

Eric W. Miller



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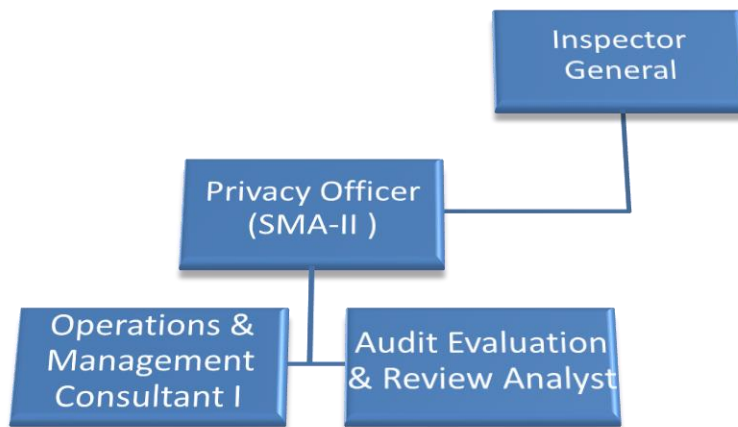
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# HIPAA Compliance Office

The Health Insurance Portability and Accountability Act (HIPAA) Compliance Office coordinates Agency compliance with HIPAA requirements pursuant to Title 45, Code of Federal Regulations, Parts 160, 162 and 164 (Public Law 104-191), and the Health Information Technology Economic and Clinical Health Act (Title XIII of Division A and Title IV of Division B of the



American Recovery and Reinvestment Act of 2009, Public Law 111-5).

The HIPAA Compliance Office staff was increased from two FTEs to three with the addition of one full-time Audit Evaluation and Review Analyst in FY 2015-16. This staffing increase enabled increased focus on policy review, risk detection, and mitigation. It also bolstered the Agency's ability to review actions of its business associates in regard to appropriate handling of privacy/security incidents and breaches. Current staff consists of the Senior Management Analyst II, who serves as the Agency's Privacy Officer (designated by the Secretary), an Operations and Management Consultant I, and the aforementioned Audit Evaluation and Review Analyst.

The HIPAA Compliance Office staff collectively have the following qualifications/certifications: Bachelor's Degree (3); Master's Degree (1); Certified Inspector General Investigator (1); Certified in Health Care Compliance (1); Certified in Health Care Privacy (2); and one staff member is pursuing Project Management Professional training and certification.

Responsibilities and activities undertaken by this three-person staff in FY 2015-16 included those mentioned below, several of which would not have been feasible to undertake without the staffing increase:

- Administered the HIPAA/Security Awareness Online Training program which is a web-based course designed to orient new Agency staff to HIPAA requirements and heighten staff understanding of computer security procedures. HIPAA staff implemented a re-designed workflow to compress the timeframe for workforce member completion of this critical training and to alert Agency management regarding non-compliance where necessary.
- Provided in-person HIPAA and HITECH privacy training to Agency employees as part of new employee orientation. This was the first year for implementation by the Agency's Bureau of Human Resources of a webinar version of annual employee training which includes HIPAA training. This resulted in a documented increase in compliance with the mandatory training requirement.
- Responded to all requests for protected health information (PHI) from Medicaid recipients or their authorized representatives within the HIPAA required timeframes and replied to emails and telephone inquiries from the public within an average of one business day.
- Provided guidance to Agency staff regarding potential privacy incidents or breach situations and ensured Agency actions in such situations were in compliance with HIPAA regulations.
- Reviewed and provided written comments/recommendations on Agency Memoranda of Understanding involving confidential data and on Medicaid Data Use Agreements.
- Reviewed all new Agency forms or forms under revision for policy compliance and provided written comments/recommendations.
- Initiated an Agency workgroup for review of Medicaid Management Information System access by entities external to the Agency. The purpose of this endeavor was (and is) to ensure such access continues to be appropriate for the Medicaid program's business needs.
- Initiated a project to convert certain documentation to Laserfiche storage and automate HIPAA office workflows and processes where feasible.

## Agency for Health Care Administration 2015-16 OIG Annual Report

- Completed a comparison of Agency HIPAA-related policies and practices with the federal audit protocols released in 2014 and 2015 by the Department of Health and Human Services, Office for Civil Rights, which is the federal HIPAA enforcement agency. This review resulted in changes to Agency policies and practices, implementation of which will continue into FY 2016-17.
- Participated in the Agency Computer Security Incident Response Team (CSIRT) as a member representing HIPAA compliance issues per Chapter 74.2, F.A.C., Information Technology Security, effective March 2016.
- Implemented an improved reporting and tracking system for Medicaid managed care plans to report HIPAA privacy and security incidents and breaches to the Agency and initiated compliance actions resulting in the potential imposition of fines on health plans for non-compliance with contractual reporting requirements.
- Continued review of Agency practices and policies presenting risk of HIPAA non-compliance and worked with Agency staff to determine root causes, such as inadequate policies, training, or management oversight, and to assist management in implementing correction thereby reducing risk of HIPAA violation or information breach. For example:
  - Records destruction policy and practices were noted to be deficient resulting in the HIPAA Compliance Office implementing weekly inspection of shredding containers at the headquarters campus for evidence of unsecured Protected Health Information (PHI). As the inspection process has continued, a downward trend in deficient practices has been noted.
  - Instances of improper PHI de-identification or redaction have originated from various Agency divisions where employees failed to use the HIPAA Safe Harbor method of de-identification. In response, the HIPAA Compliance Office has placed additional training and policy emphasis on proper redaction and de-identification techniques and has worked with the non-compliant bureaus to implement corrective actions.
  - To ensure that Office of the Inspector General (OIG) staff consistently use proper PHI redaction and de-identification practices for removal of PHI in documents prior to public release, the Privacy Officer developed an Internal Operating Procedure (IOP 15-09). The IOP contains a confidential records redaction and release process with which all OIG personnel must comply.

# Internal Audit

## Internal Audit Functions

The purpose of Internal Audit is to provide independent, objective assurance and consulting services designed to add value and improve Agency operations. Internal Audit's mission is to assist the Secretary and other Agency management in ensuring better health care for all Floridians by bringing a systematic, objective approach to evaluate and improve the effectiveness of the Agency's risk management, control, and governance processes. The scope and assignment of audits is determined by the Inspector General; however, the Agency Secretary may at any time request the Inspector General perform an audit of a special program, function, or organizational unit.

Internal Audit operates within the Agency's Office of the Inspector General (OIG) under the authority of Section 20.055, Florida Statutes (F.S.). In accordance with Section 20.055(5)(c), F.S., the Inspector General and staff have access to any Agency records, data, and other information deemed necessary to carry out the Inspector General's duties. The Inspector General is authorized to request such information or assistance as may be necessary from the Agency or from any federal, state, or local government entity.

## Risk Assessment

Internal Audit performs a risk assessment of the Agency's programs and activities near the end of each fiscal year to assist in the development of its annual audit plan. The risk assessment process includes the identification of activities or services performed by the Agency and an evaluation of various risk factors where conditions or events may occur that could adversely affect the Agency. Activities assessed consist of components of the Agency's critical functions that allow the Agency to achieve its mission. Factors used to assess the overall risk of each core function include, but are not limited to:

- The adequacy and effectiveness of internal controls;
- Changes in the operations, programs, systems, or controls;
- Changes in personnel;
- Maintenance of confidential information;
- Dependency on internal systems;
- Complexity of operations; and
- Dependency on other programs or systems external to the Agency.

## Audit Plan

Based on the risk assessment, Internal Audit develops an annual Audit Plan, which includes planned projects for the upcoming fiscal year and potential projects for the next two fiscal years.

The plan, approved by the Agency Secretary, includes activities to be audited or reviewed, budgeted hours, and assignment of staff.

### Assurance Engagements

Internal Audit also conducts assurance engagements for the Agency. These engagements consist of an objective examination of evidence to provide an independent assessment on governance, risk management, and control processes. Such engagements assess the adequacy of internal controls to ensure:

- Reliability and integrity of information;
- Compliance with policies, procedures, laws, and regulations;
- Safeguarding of assets;
- Economic and efficient use of resources; and
- Accomplishment of established objectives and goals for operations or programs.

Assurance engagements are performed in accordance with the *International Standards for the Professional Practice of Internal Auditing (Standards)* published by the Institute of Internal Auditors (IIA). Assurance engagements result in written reports of findings and recommendations. The final reports include responses from management and are distributed to the Agency Secretary, affected program managers, the Chief Inspector General, and to the Auditor General.

### Consulting Engagements

Internal Audit's consulting engagements provide assistance to Agency management or staff for improving specific program operations or processes. In performing consulting engagements, Internal Audit's objective is to assist management or staff to add value to the Agency's programs by streamlining operations, enhancing controls, and implementing best practices. Since these engagements are generally performed at the specific request of management, the nature and scope are agreed upon by Internal Audit and Agency management before commencing the requested engagement.

Some examples of consulting engagements include:

- Reviewing processes and interviewing staff within specific areas to identify process weaknesses and making subsequent recommendations for improvement;
- Facilitating meetings and coordinating with staff of affected units to propose recommendations for process improvements, seeking alternative solutions, and determining feasibility of implementation;
- Facilitating adoption and implementation of process improvement between management and staff, or between the Agency units;
- Participating in process action teams;
- Reviewing planned or new processes to determine efficiency, effectiveness or adequacy of internal controls; and
- Preparing explanatory flow charts or narratives of processes for management's use.

If appropriate, consulting engagements are performed in accordance with the *Standards* published by the IIA.

### Management Reviews

Internal Audit's management reviews are examinations of Agency units, programs, or processes that do not require a comprehensive audit. These reviews may also include compliance reviews of contractors or entities under the Agency's direct oversight. Management reviews result in written reports or letters of findings and recommendations, including responses by management. The IIA *Standards* are not cited in these particular reviews. These reports are distributed internally to the Agency Secretary and affected program managers. In addition, certain reports are sent to the Chief Inspector General and to the Auditor General.

### Special Projects and Other Projects

Services other than assurance engagements, consulting engagements, and management reviews performed by Internal Audit for Agency management or for external entities are considered special projects. Special projects may include participation in intra-agency and inter-agency workgroups, attendance at professional meetings, or assisting an Agency unit, the Governor's office, or the Legislature in researching an issue. Special projects also include atypical activities that are accomplished within Internal Audit, such as the installation of new audit tracking or training software, or making revisions to policies and procedures.

### Internal Audit Staff

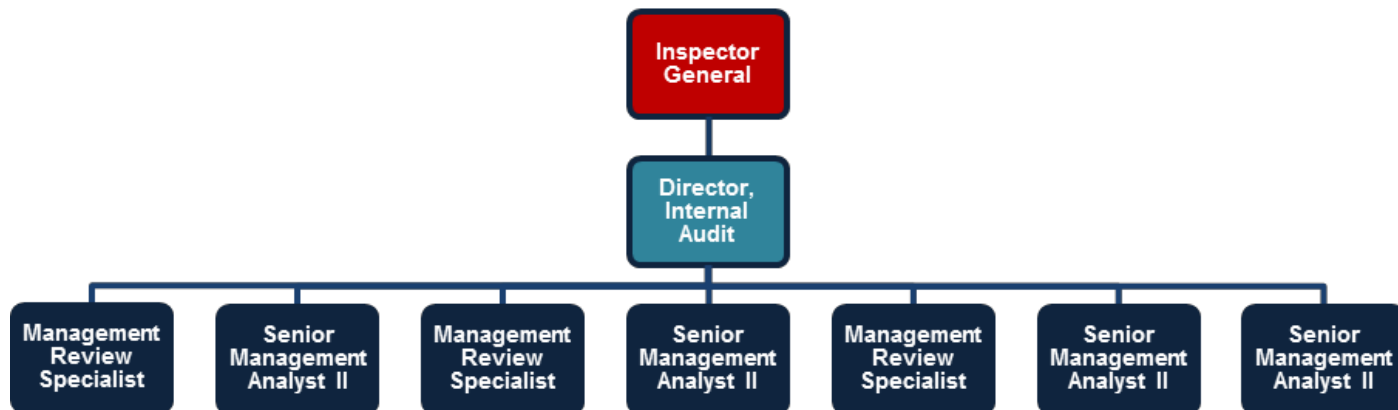
Internal Audit staff members bring various skills, expertise, and backgrounds to the Agency. Certifications or advanced degrees collectively held by members of Internal Audit include:

- Certified Public Accountant
- Certified Internal Auditor
- Certified Fraud Examiner
- Certified Information Systems Auditor
- Certified Information Systems Security Professional
- Certified ISO 20000 Internal Auditor
- Certified Inspector General
- Certified Inspector General Auditor
- Certified Government Auditing Professional
- Master of Arts in Teaching
- Master of Arts in Sociology
- Master of Public Administration
- Master of Business Administration
- Juris Doctorate in Law

The IIA *Standards (also known as Red Book Standards)* and the Association of Inspectors General *Principles and Standards for Offices of Inspectors General (also known as Green Book Standards)* require Internal Audit staff members to maintain their professional proficiency through continuing education and training. Each auditor must receive at least 40 hours of continuing education every year. To meet this requirement, staff members attend courses, conferences, seminars, and webinars throughout the year.

During this fiscal year, Internal Audit staff attended trainings sponsored by national and/or local chapters of the Association of Inspectors General, the Institute of Internal Auditors, the Association of Certified Fraud Examiners, the Association of Government Accountants, and the Information Systems Audit and Control Association. Staff also attended Agency employee training and completed Government and Nonprofit Accounting video training.

## Internal Audit Organizational Chart



## Internal Audit Activities

### Assurance & Consulting Engagements, and Management Reviews

Internal Audit completed two audits, one management review, and one consulting project during fiscal year (FY) 2015-16. The following is a summary list of engagements completed and a summary list of engagements in progress as of June 30, 2016:

**Table 1: Internal Audit Engagements**

Report No.	Engagement	Type	Month Issued
13-14	Medicaid Recipient File Management	Assurance	July 2015
16-12	MPI Position Description Research	Consulting	May 2016
15-08	Background Screening Clearinghouse Program	Assurance	June 2016
15-09	Third Party Liability Review	Review	June 2016

**Table 2: Internal Audit Engagements in Progress**

Report No.	Engagement	Type	Planned Issue Month
15-11	HQA On-line Licensing Process	Assurance	November 2016
15-16	Single Sign-On Process	Assurance	November 2016
16-08	Cash Room Collection Process	Assurance	October 2016
16-14	Medicaid Aid Category Rate Assignment	Review	October 2016
16-15	Review of Agency Agreements	Review	December 2016



## Engagement Summaries

The following summaries describe the results of the assurance engagements, consulting engagements, and reviews completed by Internal Audit during FY 2015-16:

### 13-14 Medicaid Recipient File Management

As part of the Agency's Audit Plan, Internal Audit conducted an audit of the Division of Medicaid's Recipient File Unit's (RFU) process for updating and correcting errors in the Florida Medicaid Management Information System's (FMMIS) recipient files. The scope of this engagement focused on evaluating RFU's process for correcting FMMIS recipient file errors during the period of October 2013 through March 2014 and the manual update process from March 1, 2014, through March 31, 2014. Overall, RFU's recipient file update and error correction process appeared to have adequate internal controls and adhered to sound administrative practices. However, Internal Audit noted areas where improvement could be made to strengthen controls and increase efficiency in RFU's process for correcting errors identified on FMMIS OnBase error reports. Some of Internal Audit's recommendations to the Division of Medicaid were that RFU:

- Coordinate with Department of Children and Families staff to systematically prioritize the correction of older recipient errors first (when applicable) to prevent continued reappearance in the error reports by developing an aging analysis report.
- Finalize desk procedures to standardize the OnBase report error correction process, including addressing the correction of older errors first.

### 16-12 MPI Position Description Research

The purpose of this consulting project was to identify best practices, in accordance with Agency guidelines and procedures, to consistently develop and review the Bureau of Medicaid Program Integrity's (MPI) position descriptions within the Office of Inspector General. This engagement included consultation and research to support the identified best practices. Some of Internal Audit's suggested recommendations included:

- Use a comprehensive approach to look at broadband numbers and their correlating occupational profile description to see if they properly reflect position title; align similar broadband profiles/tasks with similar position title; and review the organization chart to determine if similar or same position titles are grouped within units or at same levels of supervision if similar tasks are assigned.
- At an individual level, as outlined in the position description instructions, the supervisor should develop the position description with input and approval by the Bureau Chief; ensure that career services descriptions have percent of time spent on tasks noted; complete the Knowledge, Skills and Abilities (KSAs) component of the position description; and routinely review position descriptions as job responsibilities change.

15-08 Background Screening Clearinghouse Program

As part of the Agency's Audit Plan, Internal Audit conducted an audit of the Background Screening Unit's (BGS) operations within the Division of Health Quality Assurance (HQA). The scope of this audit was to look at internal processes as performed in calendar years 2014 and 2015. The objectives were to review the adequacy of program and system controls, and review the efficiency and effectiveness of the screening, exemption, and the provider notification process of an employee's subsequent arrest. The audit found, in general, applicable laws, rules, and established procedures were being followed. It also noted that the BGS unit notified employers of employees' rapback arrests and processed exemption applications timely. However, Internal Audit noted areas where improvement could be made to strengthen BGS controls and improve efficiency. Some of Internal Audit's recommendations to the Division of Health Quality Assurance were that BGS:

- Implement a quality assurance process and develop a sampling program that includes reviewing high risk determinations, such as criminal offenses committed in other states or the criminal history of an applicant with a large number of offenses.
- Continue to work with the Division of Information Technology to develop appropriate reports to monitor the number of days to make BGS eligibility determinations.
- Implement processes to help ensure that state agencies receive timely access to the BGS Clearinghouse.
- Develop written guidelines and procedures outlining the documents and system fields that are required to be completed and create a system edit to prevent the closure of a case unless all items in the system checklist have been checked as completed.
- Consider establishing written guidelines for processing exemption applications.
- Continue to review sealed adult criminal history records in determining eligibility.
- Finalize the process to monitor employer's actions after notification of an employee's rapback and finalize the process to fine violators.

15-09 Third Party Liability Review

At the request of the Agency Secretary, Internal Audit conducted a limited management review of the Division of Operations' Third Party Liability (TPL) Unit processes. The review focused on TPL's business process and controls for monitoring the TPL vendor's activities with regard to casualty and estate recoveries and evaluated a sample of closed cases that required legal action or Agency input to determine if the case closure decisions in the sample were adequately supported. Overall, the review disclosed that there was sufficient documentation to support closure of cases reviewed requiring legal action or Agency input. However, the review also noted that the TPL Unit did not have adequate written internal policies, procedures, or guidelines regarding monitoring of the TPL vendor contract and did not adequately document monitoring of the TPL vendor's handling of casualty and estate recovery cases. Some of Internal Audit's recommendations to the Division of Operation were that the TPL Unit:

- Develop written contract monitoring procedures.
- Document and formalize monitoring of the TPL vendor’s activities and communication with the vendor.

### Additional Projects

Section 20.055(2), F.S., requires the OIG in each state agency to “advise in the development of performance measures, standards, and procedures for the evaluation of state agency programs” and to “assess the reliability and validity of the information provided by the state agency on performance measures and standards, and make recommendations for improvement, if necessary.”

Internal Audit participated in the review of performance measures included in the Agency’s annual Long Range Program Plan (LRPP). Current measures and proposed new measures were reviewed and advice was provided to the Agency staff regarding accuracy, validity, and reliability.

Internal Audit completed the following additional duties or projects during FY 2015-16:

- Chief Inspector General Quarterly Activity Reports;
- Schedule IX of the Legislative Budget Request;
- Summary Schedule of Prior Audit Findings;
- Department of Health and Human Services Audit Resolution Letter;
- Contributed to OIG Annual Report;
- Engagements in Progress Report;
- Auditor General Quality Assurance Review;
- Tracking of all HHS Demand Letters and Documentation Requests for Resolution of Audit Findings;
- Annual Risk Assessment; and
- Annual Audit Plan

### Internal Engagement Status Reports

The IIA *Standards* require auditors to follow-up on reported findings and recommendations from previous engagements to determine whether Agency management has taken prompt and appropriate corrective action. The OIG provides status reports on internal engagement findings and recommendations to Agency management at six-month intervals after publication of an engagement report.

During FY 2015-16, the following status reports for internal engagements were published:

- 15-20 Agency Accounts Receivable Process (24-Month Status Update)
- 16-01 Adverse Incidents Report Process (18-Month Status Update)
- 16-02 MCM Provider Enrollment Process Audit (18-Month Status Update)

## Agency for Health Care Administration 2015-16 OIG Annual Report

- 16-03 Assessment of MCOs' Anti-Fraud Plans (12-Month Status Update)
- 16-04 Provider Payment Suspension and Termination Processes Review (24-Month Status Update)
- 16-05 Recipient File Management (6-Month Status Update)
- 16-06 Adverse Incidents Report Process (Final Status Update)
- 16-07 Provider Enrollment Process Audit (Final Status Update)
- 16-09 Pre-Admission Screening and Resident Review Process (6-Month Status Update)
- 16-10 Pre-Admission Screening and Resident Review Process (Final Status Update)
- 16-11 Assessment of MCOs' Anti-Fraud Plans (18-Month Status Update)

### Corrective Actions Outstanding from Previous Annual Reports

As of June 30, 2016, there were no corrective actions for significant recommendations described in previous annual reports that were still outstanding:

### External Engagement Status Reports

Pursuant to Section 20.055(5)(h), F.S., the OIG monitors the implementation of the Agency's response to external reports issued by the Auditor General and by the Office of Program Policy Analysis and Government Accountability (OPPAGA). The OIG is required to provide a written response to the Secretary on the status of corrective actions taken no later than six months after a report is published by these entities. Copies of such responses are also provided to the Legislative Auditing Committee. Additionally, pursuant to Section 11.51(3), F.S., OPPAGA submits requests (no later than 18 months after the release of a report) to the Agency to provide data and other information describing specifically what the Agency has done to respond to recommendations contained in OPPAGA reports. The OIG is responsible for coordinating these status reports and ensuring that they are submitted within the established timeframes.

During FY 2015-16, status reports were submitted on the following external reports:

- Auditor General – State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2015-166)

### Coordination with Other Audit and Investigative Functions

The OIG acts as the Agency's liaison on audits, reviews, and information requests conducted by external state and federal organizations such as the Florida Office of the Auditor General, the Florida Department of Financial Services, OPPAGA, U.S. Department of Health and Human Services, the Social Security Administration, and the U.S. Government Accountability Office (GAO). The OIG coordinates the Agency's responses to all audits, reviews, and information requests from these entities.

# Agency for Health Care Administration 2015-16 OIG Annual Report

During FY 2015-16, the following reports were issued by external entities:

## **Office of the Auditor General**

- Auditor General – State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2016-159)
- AHCA – Office of Inspector General’s Internal Audit Activity (Report No. 2016-042)

## **FDLE<sup>1</sup>**

- Non-Criminal Justice Agency Technical Audit (FDLE letters dated in March and April 2016)

## **DFS**

- Audit of Selected Contract and Grant Agreements and Related Contract and Grant Management Activities for AHCA (issued December 2015)

## **OPPAGA**

- OPPAGA Research Memorandum – Health and Human Services Contact Centers/Hotlines (issued May 2016)
- AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments (Report No. 16-03)

## **GAO**

- Medicaid – Additional Reporting May Help CMS Oversee Prescription-Drug Fraud Controls (Report No. GAO-15-390)
- Nursing Home Quality – CMS Should Continue to Improve Data and Oversight (Report No. GAO-16-33)
- Medicaid Program Integrity – Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers (Report No. GAO-16-402)
- Medicaid – Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments (Report No. GAO-16-108)

## **HHS**

- U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for FY 2014 (Report No. A-17-15-52000)
- Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure (Report No. OEI-04-11-00590)
- Providers Terminated from One State Medicaid Program Continued Participating in Other States (Report No. OEI-06-12-00030)

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<sup>1</sup> The External Audit’s root cause analysis excludes any Non-Criminal Justice Agency Technical Audit findings due to the exempt and or confidential nature of the audit in accordance with Section 282.318(4)(g), Florida Statutes.

## New Audit Capabilities

Internal Audit purchased and implemented MKinsight, an audit management system, in FY 2015-16. This new audit management system was required because the prior audit management system, Audit Leverage, was incompatible with MS Office versions newer than 2010.

Over the last year, Internal Audit worked with the vendor to configure MKinsight so that it would mirror our audit methodology. MKinsight tracks work performed on audits, management reviews, consulting projects, special assignments, follow-up activities, and risk assessments. The system assists with ensuring compliance with Section 20.055, F.S., the *International Standards for the Professional Practice of Internal Auditing*, and other requirements by embedding such standards into its configuration. The vendor also provided three days of on-site training to all Internal Audit staff. The official Go-Live date was June 30, 2016. All new audits from the 2016-17 audit plan will be performed using MKinsight.

The purchase of MKinsight allows Internal Audit to maintain and improve productivity, to continue to ensure standards are met, and efficiently accomplish its mission to bring a systematic, disciplined approach to evaluate and improve the effectiveness of Agency risk management, controls, and governance processes.

## Root Cause Analysis

Both internal and external audits, and follow-ups on previous audit reports showed recurring themes or deficiencies in the following areas:

- Policies or Procedures – Nonexistent, outdated, or inadequate policies or procedures.
- Process – Inadequate process or failure to address risk in a process.
- Documentation – Lack of supporting documentation or failure to maintain documentation to show compliance with procedures, laws, contracts, statutes, interagency agreements, or other governing documents.
- Monitoring or Reporting – Inadequate monitoring, supervisory review, or reporting of compliance with policies, procedures, contracts, or other established standards.

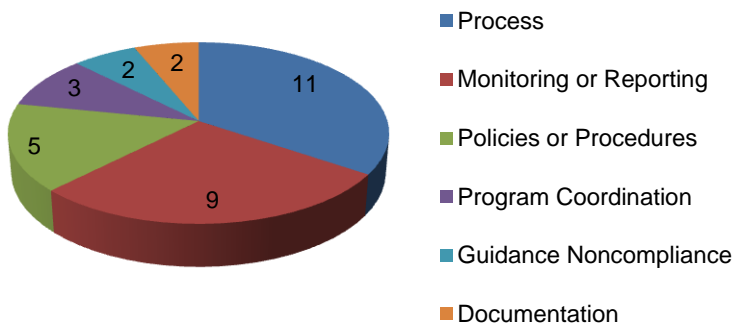
Other Areas showing recurring themes or deficiencies are as follows:

- Contract or Agreement Deficiency – Deficiencies in contract requirements; interagency agreements; outdated rules; and noncompliance with statutory requirements.

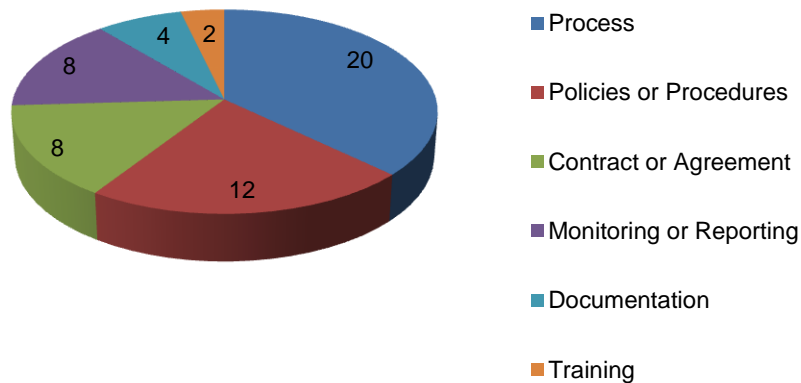
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- Noncompliance with Federal Guidance or Legislative Appropriations – Noncompliance with federal CMS guidance or legislative appropriation payment limitations.
- Program Coordination – Failure to verify the completeness or accuracy of Medicaid provider ownership information, check exclusion databases, or ensure that Medicaid providers terminated for cause in other states did not continue to participate in Medicaid in their own states.
- Training - Inadequate employee training.

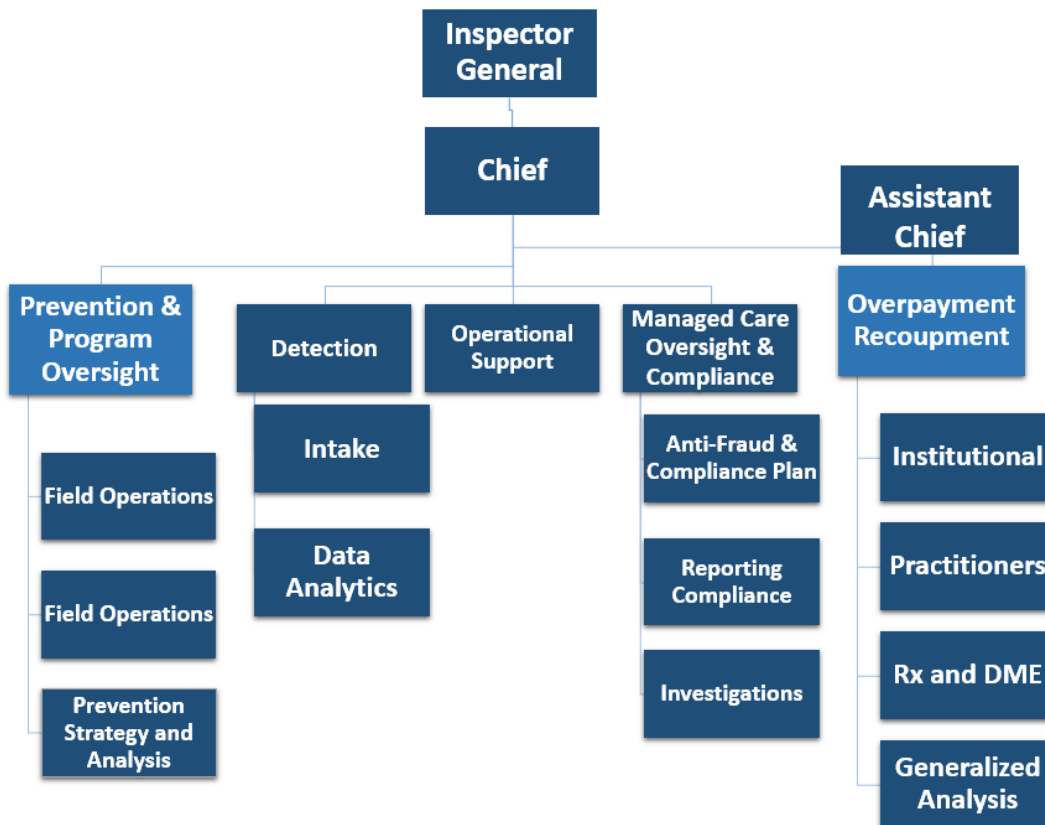
## External Audits Root Cause Analysis



## Internal Audits Root Cause Analysis



# Medicaid Program Integrity (MPI)



The Office of Medicaid Program Integrity (MPI) is a unique component of AHCA's Office of Inspector General in that most Florida inspectors general offices do not house an administrative enforcement arm within their structure. MPI derives its authority from ss. 409.913 and 409.91212, Florida Statutes, laws relating to the integrity of the Medicaid program, and s. 20.055, Florida Statutes, the Agency inspectors general statute. Recognizing its unique and essential role, MPI strives to ensure that Medicaid payments are made to appropriate providers for eligible services rendered to eligible Medicaid recipients.

This is accomplished through a number of operational functions ranging from the detection of misspent funds, the imposition of administrative actions and sanctions, and the coordination of activities that serve to deter or prevent fraud, abuse, and overpayments in the Medicaid program.



In addition, as appropriate, MPI prepares referrals to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General and to other regulatory and criminal investigative agencies.

### Detection

MPI activities begin with detection of possible fraud, program abuse, or Medicaid overpayment within the Medicaid program. Detection is one of the most important and challenging aspects of the work due to the dynamic nature of fraud and abuse and the sheer volume of claims for payment received annually by the Florida Medicaid program. While fee-for-service claims processed through the Medicaid program are subjected to system edits, edits cannot discover the intent of the individual or entity submitting the claim; they cannot detect when goods or services were not medically necessary or were not actually provided; and they cannot determine when the goods or services were rendered contrary to established Medicaid policy.

MPI detection efforts include the analysis of information received from external sources, such as an online complaint form, as well as the analysis of claims using internal tools developed and refined by MPI. Software supplied by the Medicaid fiscal agent contractor complements MPI's own software to detect the upcoding of claims (the billing of higher paying procedure codes than warranted for the services actually supplied). During FY 2015-16 through mid-May 2016, MPI received more than 1,700 complaints of various allegations. The vast majority (approximately 75%) of the complaints were received from the MPI online complaint form. Other complaint sources include the MPI data analytics system, referrals from the Centers for Medicare and Medicaid Services, other units within AHCA, and other state agencies. MPI also initiates its own leads through legacy detection tools and investigator initiatives.

During FY 2015-16, the Agency and SAS Institute, Inc. (SAS) entered into a second-year contract for data analytics (executed on October 29, 2015). MPI and SAS implemented the initial efforts of a data analytics system to significantly enhance the number of investigation-ready leads for MPI through the analysis of both internal and external data sets. This system, through the user interface designed to meet MPI's needs, will contain more than 8,000 leads for MPI to process from intake, through assessment and preliminary investigation, to a disposition.

The data is refreshed approximately every other month, resulting in an expectation that MPI will see an increase of more than 400% of its typical complaint volume. The data analytics contract requires SAS to provide investigative-ready leads, defined as "more than simply system flags or alerts, but information referred to the Agency that has undergone a preliminary analytic review." The leads are also required to identify "suspicious behavior patterns" and include "the reasoning or methodology for the suspicion, and recommended actions." To increase efficiencies and effectiveness that directly impacts the success of the project, MPI has proposed a leads assessment process wherein at each data refresh, a random sample of the leads which exceed a predefined standard (lead score value) will be prioritized for review.

MPI and SAS are still discussing the standard, but MPI believes that the majority of the leads should be actionable for the system to be considered a good value for the state. MPI is now incorporating thresholds in future contracts to ensure that the excessive volume of false positives is mitigated.

Through the end of April 2016, approximately nine months into the initial implementation, information from data analytics has assisted MPI with the identification of more than 200 new provider complaints. While the assessment and preliminary investigation of about half of the leads remains underway, audits continue to be initiated, and as they are finalized, the results will be published through standard Agency processes (Agency Final Orders may be found on the AHCA website under “public records”). In fact, one audit has an identified overpayments in excess of \$500,000 (the case is not yet final and is subject to appeal by the provider). Additionally, more than \$1 million in cost savings are attributed to MPI prepayment reviews.

## External Audits/Provider Overpayment Recovery Activity

Once a suspected overpayment or program abuse activity is identified, whether it is a suspicious claim submission by a Medicaid provider or some other complaint that suggests a Medicaid provider warrants closer review, MPI initiates a preliminary investigation of the activity to determine the nature and potential extent of the violations. This assists MPI in determining whether the allegations should be referred to other entities, including MFCU, for investigation of potential fraud.

Program abuse involves Medicaid billings that are inconsistent with generally accepted practices, resulting in unnecessary costs. When activity appears to involve misbilling without rising to the level of fraud, MPI conducts comprehensive audits with the intended outcome to be the recovery of Medicaid overpayments.

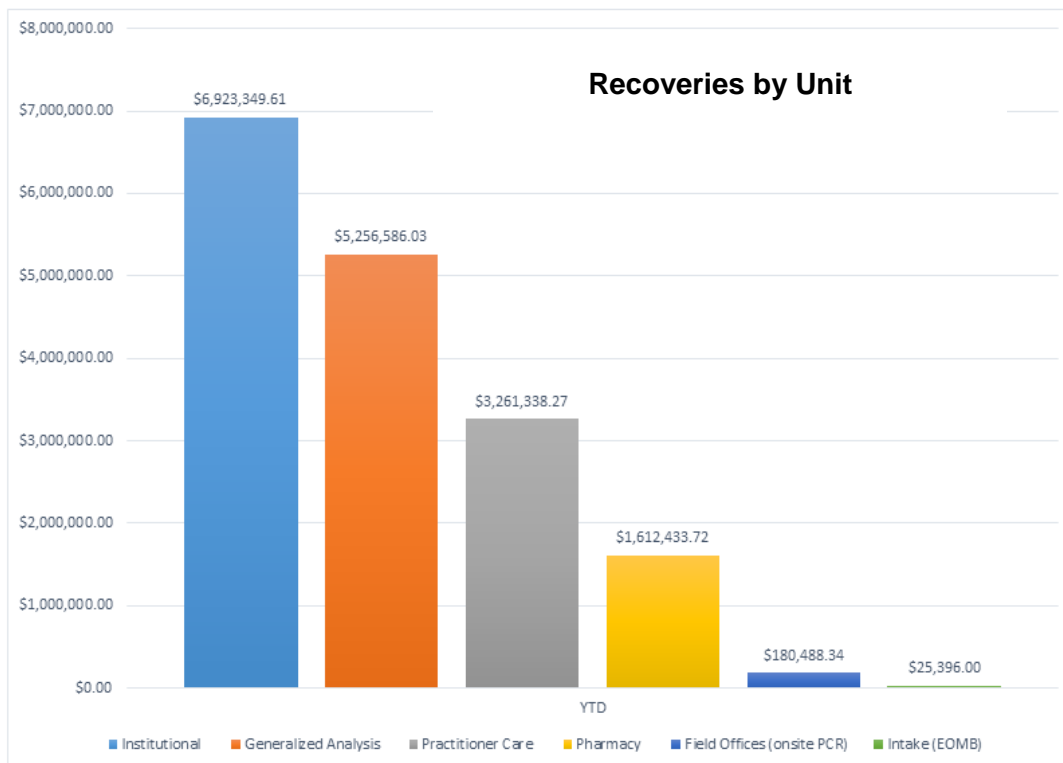


MPI conducts audits of Medicaid providers through the review of professional records, generalized analyses, and focused audits. Generalized analyses typically do not involve record reviews and most often focus on policy violations that are supported by claims data analysis alone. They also commonly involve many provider audits, compiled into a single project. MPI audits, through the end of April 2016, have resulted in the recovery of more than \$17 million in overpayments, with more than

## Agency for Health Care Administration 2015-16 OIG Annual Report

\$70 million preliminarily identified and subject to future recovery.

MPI anticipates that in FY 2016-2017 it will work with Medicaid managed care contractors to continue to achieve the high level of results that have been historically realized by MPI. MPI will work more closely with the contracted health plans to increase effectiveness within the managed care environment so that the overpayment-related recoupments that the health plans identify are increased to meet or exceed MPI's historical averages. With the move to Statewide Medicaid Managed Care (SMMC), there is a significant decrease in fee-for-service (FFS) claims; however, MPI activities are increasing. FFS recoupments are at an all-time high with efforts to ensure comprehensive retrospective reviews and audits are able to effect recoveries for services rendered as far back as five years. Additionally, MPI recoupment activities are beginning to touch on the period immediately preceding the implementation of the SMMC program, a time period that saw the annual FFS claims volume expand to as many as 127,000,000 claims in a 12-month period.



Also, there are several Medicaid eligible populations that remain FFS following the full implementation of SMMC.

To the extent that the health plans are able to keep would-be fraudsters out of their networks, these remaining FFS populations create an increased vulnerability for the state related to fraud, waste, and abuse. These populations continue to have a high volume of reimbursement (approximately \$800,000,000) that will warrant ongoing auditing and recoupment activities by MPI.

### Managed Care Plan Oversight

Within MPI there is a Managed Care Unit (MCU) consisting of three sub-units. Their primary responsibilities are related to the Medicaid health plan requirements for filing organizational strategies and documents pertaining to their corporate culture; fraud and abuse investigation requirements; investigation of allegations of health plans being involved in fraudulent or abusive activities; and audits of health plans related to specific statutory and contractual requirements.

Health plans are required to submit a compliance plan and anti-fraud plan, including related fraud and abuse policies and procedures, and any changes to these items to MPI for written approval at least 45 days before those plans and procedures are implemented (see s. 409.91212, F.S. and 409.967(2)(f), F.S.). Federal regulations (42 CFR 438.608) also require that the health plans “have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.” The law provides for specific procedures, including designated policies, staff, training requirements, and organization.

MPI is responsible for the review and assessment of all reports of suspected or confirmed fraud and abuse submitted by the health plans. These reports come through MPI’s intake operations and standard processes address any MPI-related actions (audits or referrals). The MCU review assesses the timeliness and quality of the referral itself. The MCU is responsible for monitoring the health plans’ investigations to ensure the plans are diligently pursuing overpayments. Additionally, MPI provides assistance and guidance to the health plans regarding accurate reporting of suspected fraud and abuse to the Agency.

The MCU also has an Investigations Unit responsible for evaluating all complaints in which the subject of the alleged fraud or abuse is a Medicaid health plan. All allegations are first assessed by MPI to determine if they should immediately be referred to MFCU or whether the allegations are too ambiguous to determine if they actually allege a violation of law. In instances when there is a high level of reliability of the complainant and the supporting evidence suggests

a high level of validity to the allegations, they are referred to MFCU after the preliminary assessment by MPI. Managed care investigations may involve an alleged failure to comply with legal requirements for a program integrity unit (or special investigative unit). The allegations are typically related to inefficient auditing or a lack of contractor Special Investigative Unit (SIU) expertise sufficient to diligently pursue anti-fraud activities, or involve allegations that a Medicaid health plan is contracting with a provider or providers who have been excluded from Medicare or Medicaid.

The MCU also facilitates periodic meetings that are held with the contracted Medicaid health plans. The meetings have evolved over the last few years and provide a collaborative environment for the health plans, the Agency, and other state and federal partners to share current concerns regarding providers that may be contributing towards fraud, waste, and abuse. The shared information assists the plans as well as MPI and MFCU in furthering effective investigations. These meetings also provide a forum for investigative best-practices discussions, including referral processes, while providing deeper insight into the processes and practices of the Agency, MFCU, and the health plans. This collaboration and developing trust between the health plans, the Agency, and MFCU aids in fighting fraud in the Medicaid program and encourages the health plans to improve their internal quality controls regarding fraud and abuse reporting to the Agency.

The MCU also conducts onsite inspections of each Medicaid health plan each fiscal year. During these inspections, assigned staff members from MCU meet with Medicaid health plan staff to assess various plan operations that are both compliance-related as well as related to the plan's fraud, abuse, and waste programs. Historically, these assessments have been broad-based assessments of the Medicaid health plans' operations. Current processes focus staff resources on those areas identified as higher risk for non-compliance or greater vulnerabilities for fraud, abuse, and waste by the plan or the plan's network providers. These assessments have confirmed that the Medicaid health plans have the same, if not greater, vulnerabilities as in a fee-for-service program. MPI is positioned to assist Medicaid health plans lower program risk and provide policy recommendations to ensure program safeguards are in place where necessary.

Finally, the MCU also conducts audits of managed care plans related to specific issues of potential non-compliance with statute or rule. For example, in FY 2015-16, MPI's MCU engaged in an audit of all Medicaid managed care plans and their related hospital provider networks to determine compliance with section 409.975(6), F.S. The review included all Medicaid managed care plans that were then operating in Statewide Medicaid Managed Care (SMMC). The review also included managed care plans formerly operating in SMMC and which continue to be under the authority of the Agency with regard to regulatory oversight, whether due to law or survivability provision of the contract.

This audit, completed in late 2015, evaluated 167 hospitals and 19 Medicaid health plans' financial arrangements to determine whether provider rates, payment methods, and terms of payment were consistent with the governing law. MPI's audit identified non-compliance, resulting in focused audits related to each of the specific plans and hospitals with suspected non-compliance. These subsequent audits remain in process.

### Prevention

MPI Prevention includes three units, two of which predominately focus on on-site provider reviews and prevention projects. One of the three units is located in the Agency's Miami Area Office and takes a lead responsibility for field operations in South Florida. The second unit includes staff based in Jacksonville, Orlando, and Tampa (JOT) and is managed out of the Agency's Tampa Area Office. The third unit, located in Tallahassee, provides guidance, research, support to the other Agency divisions, and assists with complex investigations related to fraud prevention.

Through mid-May 2016, MPI conducted many on-site field initiatives, some of which are described below.

- Applied Behavior Analysis Services – Identified providers not in compliance with Medicaid policy and ensured that appropriate ordered services were provided to Medicaid recipients.
- Speech Therapy Services – Identified providers out of compliance with Medicaid policy, ensured that appropriate ordered services were provided to Medicaid recipients, and assessed billing practices for services rendered.
- Durable Medical Equipment (DME) Back Brace Services – Identified providers who billed for procedure code L0631-Lumbar-sacral orthosis, sagittal control with rigid anterior and posterior panels (back braces) to assess compliance with Medicaid policy, including necessity and ordering of services. The objective of the initiative was to verify that qualified licensed personnel were providing direct services to Medicaid recipients and that DME providers were not up-coding and billing Medicaid for the more expensive back brace (POC L0631) while furnishing Medicaid recipients with a less expensive pre-fabricated off-the-shelf type brace.
- Assistive Care Services – Completed compliance site visits to six currently active Medicaid ALF providers in Palm Beach County to assess compliance with Medicaid policy and to assess billing practices for services rendered. These ALF providers were identified as having billed at or close to their licensed capacity.

The objective of the initiative was to determine if ALF providers were over their licensed capacity and if qualified and properly trained staffs were rendering Assistive Care Services (ACS).

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- Suboxone Prescribing – Conducted on-site reviews of currently active Medicaid physician providers who prescribed Suboxone to assess compliance with The Drug Addiction Treatment Act (DATA) of 2000 and Medicaid policy.
- Sleep Apnea Devices – Performed on-site reviews of currently active Medicaid DME providers to assess compliance with the Florida Medicaid Provider General Handbook (July 2012) and the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010). Also assessed billing practices for services rendered.
- Pharmacy Services – Conducted statewide information gathering to assist with determining valid audit candidates.
- Home Health Services – Reviewed home health agencies which provide developmental disability waiver services to the same beneficiaries. Determined that providers did not always comply with documentation requirements.
- Data Analytics Validation visits – Launched a statewide effort to evaluate the accuracy of the newly implemented data analytics system alerts by conducting site visits to providers referred to MPI by the new alerts.

Additionally, the Tallahassee-based Prevention Unit is responsible for the referrals made to MFCU and related payment restrictions. Payment restrictions include the “pending” of claims in the Medicaid claims processing system for one or more specific, legally-authorized purposes.

Claims may be pended due to enrollment issues, claim processing issues, or other administrative matters handled by the Medicaid Bureau of Fiscal Agent Operations (FAO). Claims may also be pended at the direction of another bureau (via notice to FAO) and are typically due to an investigation by MPI. Typical pends or payment restrictions used by MPI include:

- (1) prepayment review (PPR) consistent with s. 409.913(3), F.S.;
- (2) a payment withhold following a determination that there exists reliable evidence of circumstances related to fraud or abuse (referred to as a “25A withhold”) consistent with s. 409.913(25)(a), F.S.; or
- (3) a payment suspension following a determination that there are credible allegations of fraud (referred to as a “CAF payment suspension”) consistent with 42 CFR 455.23.

Through mid-May 2016, MPI imposed approximately 80 CAF payment suspensions, approximately 30 25A withholds, and approximately 165 PPRs. Also during this time, there have been approximately 170 provider referrals to MFCU, a substantial increase over prior years.

### MPI Training Program

In January 2016, MPI formalized its assessment and training processes to ensure that its professional development needs were identified and addressed. The MPI training protocol identifies eight core educational components to serve as the basis for MPI members' professional development. MPI personnel assess their knowledge in these core components and, consistent with the training protocol, develop and implement a professional development plan to acquire and maintain knowledge in the core components. For purposes of documenting staff participation in training, MPI personnel maintain a personal training log.

Additionally, MPI implemented a voluntary certification process that allows MPI personnel to demonstrate their knowledge of the eight core educational components. Knowledge within the eight core educational components will optimize the ability for MPI personnel to perform effectively within MPI. The eight components are (1) Florida Medicaid, (2) Federal Medicaid, (3) Florida Law Related to Program Integrity, (4) Federal Law Related to Program Integrity, (5) Florida Program Integrity Procedures, (6) Principles of Program Integrity, (7) Principles of Investigations, and (8) Theory and Principles of Fraud/Criminology.

MPI serves in a lead role for the Agency with regard to oversight and accountability within the Florida Medicaid program. A basic understanding of the state's medical assistance program, including eligibility, service delivery options (e.g., managed care vs. fee-for-service), categories of service (optional vs. mandatory), and the operational structure of the single state agency and its operating partners, serves as the cornerstone of MPI knowledge. With this basic foundation, MPI personnel recognize important distinctions between Florida's program and that of other states. Also, because Medicaid is a federal-state partnership, MPI personnel comprehend the federally mandated coverage obligations and the availability of certain waivers to the state, as well as the broad federal programmatic obligations that frame the state's program.

No program integrity educational plan would be complete without strong emphasis on the law and theories related to program integrity. In Florida, the provisions of section 409.913, Florida Statutes, are critical for every day operations of MPI. Also, other laws apply, such as ss. 409.9131, and 409.91212, F.S., as well as Florida Administrative Code provisions pertaining to Florida Medicaid provider sanctions, Medicaid policies, and Medicaid coverage and limitation handbooks (as well as the incorporated handbooks). State laws pertaining to health care fraud and related misconduct that MPI may encounter routinely include ss. 409.920 and 456.053, F.S., also known as the "Patient Self-Referral Act of 1992." The provisions of state Inspector General (IG) laws and numerous federal laws are important, including 42 CFR 455.23 and 42 CFR 1007, as well as the laws that establish the federal Medicaid program framework.



Other laws and acts, such as the Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, as well as HIPAA and HITECH, include important provisions that impact MPI operations and controls.

MPI recognizes and authorizes Internal Operating Procedures (IOPs) for specific guidelines to help form the day to day structure that MPI generally follows to maintain consistency, efficiency, and accuracy. Other policies and procedures, such as those implemented for the broader Office of the Inspector General, may also apply. There are a range of considerations that are acknowledged when comprehending the operations, functions, and limitations of a program integrity unit. The functions of MPI are formed and organized based upon these broad theoretical categories of prevention, detection, and enforcement.

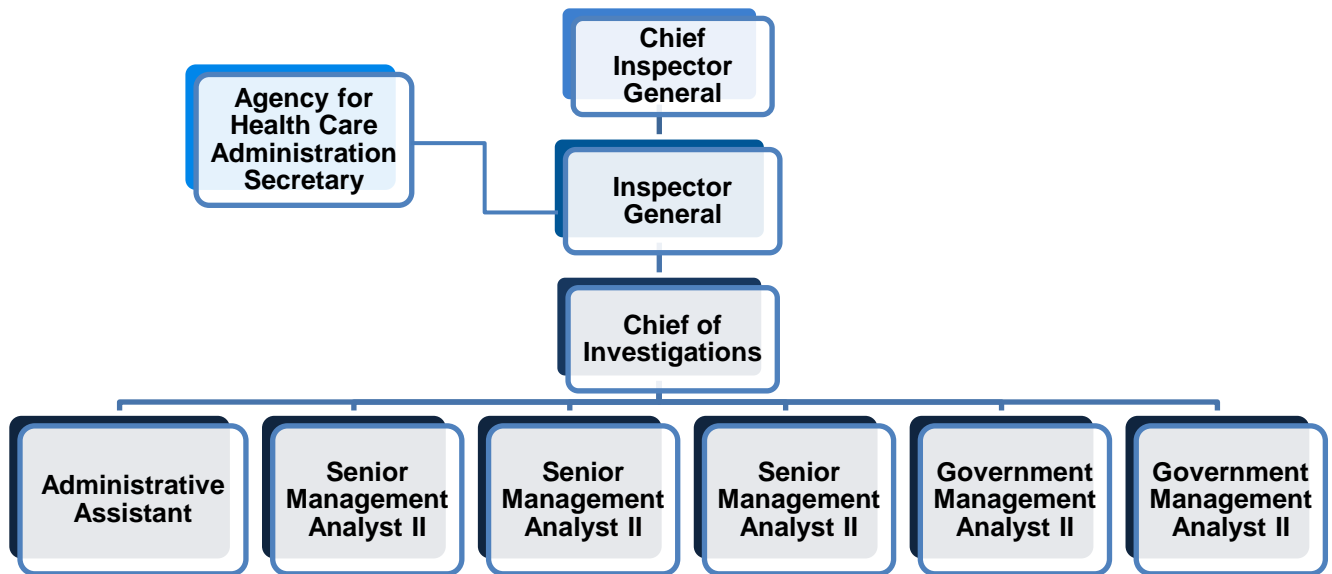
Finally, the principles of investigations and the theory and principles of fraud/criminology establish the framework for MPI operations. Principles of Investigations form the framework used to conduct all investigations at MPI. An important consideration is that all cases or complaints should be investigated from the outset with the understanding that the case may result in judicial proceedings, either in criminal or civil court or administrative hearings. The principles and theories of fraud (especially white collar crime and financial crimes) and criminology offer a foundation to approach almost all prevention and detection activities. These theories aid MPI in developing innovative approaches to emerging trends and the dynamic nature of program integrity in health care.

As of mid-May, more than half of MPI's personnel have attained the Associate Level MPI certification. Additionally, MPI has approximately ten Certified Fraud Examiners, approximately ten Certified Professional Coders, two Accredited Healthcare Fraud Investigators, and one Certified Inspector General Auditor. MPI anticipates increasing the internal and external certifications held by its staff as further demonstration of the high-caliber personnel working within the Bureau.

### [Annual Fraud and Abuse Report](#)

The results of these MPI activities are presented annually in a report entitled, *The State's Efforts to Control Medicaid Fraud and Abuse*. This report is published by January 1 of each year to reflect the prior fiscal year's efforts. It is a joint report, detailing the combined efforts of MFCU and AHCA, submitted to the Legislature pursuant to Section 409.913, F.S. The past several years' versions of the report are available on the Agency's internet site. The report to be published by January 1, 2017, will also be placed on the website and will include the most current published details about MPI activities.

# Investigations Unit



The Office of the Inspector General's Investigations Unit (IU) is responsible for initiating, conducting, and coordinating investigations that are designed to detect, deter, prevent, and eradicate fraud, waste, mismanagement, misconduct, and other abuses within the Agency. To that effort, the IU conducts internal investigations of Agency employees and contractors related to alleged violations of policies, procedures, rules, and Florida laws. Complaints may originate from the Office of the Chief Inspector General, the Whistleblower Hotline, the Chief Financial Officer's "Get Lean" Hotline, Agency employees, health care facilities, practitioners, Medicaid beneficiaries, or from the general public.

Allegations of a criminal nature are immediately referred to the appropriate law enforcement entity for investigation. When necessary or requested, the IU works closely with local police, the Florida Department of Law Enforcement, the Office of the Attorney General, and the appropriate State Attorney's Office on matters involving the accountability or integrity of Agency personnel.

## Staff and Organization

Investigations staff brings various backgrounds and expertise to the Agency. Certifications, in addition to advanced degrees, collectively held by IU staff as of June 30, 2016 include:

- Certified Compliance and Ethics Professional;
- Certified Fraud Examiners;
- Nationally Certified Inspector General Investigators;
- Certified Equal Employment Opportunity investigators;
- Certified Law Enforcement Analysts;
- Former law enforcement criminal intelligence/investigative analysts;
- Former law enforcement officers;
- Current deputy sheriff reserve officer; and
- Current police reserve officer.

## Investigations Unit Functions

During FY 2015-16, the Investigations Unit (IU) addressed 200 complaints. For the purpose of this report, the complaints were categorized as follows:

- Employee Misconduct - Allegations associated with employee misconduct included but were not limited to allegations associated with conduct unbecoming a public employee, ethics violations, misuse of Agency resources, and unfair employment practices.
- Other – Allegations not within the OIG’s jurisdiction; information provided wherein no investigative review, referral, or engagement was required.
- Facility - Regulated and licensed facility violations reported included but were not limited to allegations associated with substandard care, public safety concerns, facility licensing issues, and unlicensed activity.
- Medicaid Fraud - Medicaid fraud violations reported included but were not limited to allegations associated with Medicaid billing fraud, allegations related to patient brokering, and allegations of physician self-referral (Stark Law) violations.
- Equal Employment Opportunity (EEO) Violations - EEO violations reported included but were not limited to allegations associated with discrimination, harassment, and retaliation for engaging in protected activity.
- Health Insurance Portability and Accountability Act (HIPAA) Violations – Allegations associated with violations of HIPAA’s Privacy Rule or records access rule.
- Medicaid Service Complaints - Medicaid service complaints included but were not limited to allegations associated with reported denials of service, denials of eligibility, and Medicaid provider contract violations.

## Agency for Health Care Administration 2015-16 OIG Annual Report

During FY 2015-16, 10 of the 200 complaints received required analyses to determine if the complaints met the criteria for Whistle-blower status as defined in §112.3187 F. S.. Two of the 10 complaints met qualifying Whistle-blower criteria.

During FY 2015-16, the OIG IU closed 196 complaints and continued to investigate and/or monitor the investigation of two active legacy Whistle-blower complaints that were referred to external agencies.

During FY 2015-16, twenty-two Employee Misconduct complaints were received. The IU's analysis of the Employee Misconduct complaints received and investigated disclosed the majority of these cases involved disparaging remarks and unprofessional conduct directed toward employees and persons outside the agency.

The IU referred eighty-four complaints to other AHCA bureaus or outside agencies during FY 2015-16 for proper assessment. Seven cases were referred to law enforcement agencies for criminal investigations.

Investigations that resulted in published investigative reports were distributed to the leadership responsible for the employee or program investigated to enable leadership to effect subsequent remedial action (if appropriate) or to effect recommended policy changes. In all instances, the OIG IU's published reports were presented to the Agency Secretary for review prior to management's review, resolution, and action.

The following are examples of internal investigation cases closed during FY 2015-2016. An index of complaints received during this reporting period is included at the end of this section.

## Internal Investigation Case Highlights FY 2015-16

### AHCA OIG #15-07-004

This investigation was predicated by an anonymous complaint that alleged an AHCA employee had received bribes and kickbacks in the course of their employment with AHCA.

The AHCA OIG's investigation disclosed no evidence of the allegation that the accused AHCA employee had received bribes or kickbacks during their employment. The allegation against this AHCA employee was unsubstantiated.

### AHCA OIG #15-08-003

This investigation was initiated when the AHCA OIG received notification that an AHCA employee may have engaged in activities associated with conduct unbecoming a public employee while operating in an official capacity at an AHCA licensed and regulated facility.

The AHCA OIG's investigation found that although comments made by the AHCA employee may have been unprofessional and inappropriate, there was insufficient evidence to indicate these comments rose to the level of violating specific AHCA policies or Rule 60L-36.005, FAC, regarding Conduct of Employees.

### AHCA OIG #15-11-017

This investigation was initiated when the AHCA Bureau of Human Resources forwarded the AHCA OIG a copy of an AHCA Discrimination/Sexual Harassment Complaint Form completed by an AHCA employee in which the complainant alleged a co-worker had engaged in activities constituting sexual harassment.

The OIG AHCA investigation found that the complainant's allegation of sexual harassment against the co-worker was unsubstantiated. However, the investigation found that certain conduct, contact, and behavior by the co-worker toward AHCA employees in the workplace constituted conduct unbecoming a public employee by being discourteous, inconsiderate, or disrespectful, a violation of 60L-36.005(3)(f), Florida Administrative Code (FAC).

### AHCA OIG #15-12-001

During the course of an investigation into a sexual harassment complaint, the AHCA OIG was provided with testimonial evidence that indicated the subject of the sexual harassment complaint was misusing state resources.

A forensic review of the subject's AHCA assigned computer disclosed in excess of 350 files that did not appear work related, but instead appeared to be school related. Additional testimonial

evidence was supplied to suggest the subject was taking more office supplies than one person could use for their daily AHCA activities. Although the documentary and testimonial evidence supported the allegation that the subject had misused AHCA resources, the AHCA OIG's investigation disclosed that the subject's current and former supervisors knew of the alleged actions of the subject; however, failed to suggest or implement corrective action.

AHCA OIG #15- 12-018

This investigation was initiated following a complaint received from the Florida Department of Children and Families alleging an AHCA employee accessed Florida Safe Families Network (FSFN), "without a legitimate business reason." FSFN is used by AHCA employees to obtain information for verification of Medicaid cases and to confirm a household's composition.

When interviewed, the complainant was unable to provide sufficient information or reasonable cause to support the allegations. The AHCA OIG contacted the Division of Health Quality Assurance's (HQA)'s Chief of Field Operations, who advised that the subject may engage with clients in AHCA licensed medical facilities who have been subjected to abuse and would then have an authorized need to access FSFN. The AHCA OIG's review of evidentiary documentation and statements was insufficient to support the initial allegation and the case was subsequently referred to AHCA's Division of Health Quality Assurance for their review and for any action they deemed appropriate.

AHCA OIG #16-02-001

A complainant alleged discrimination on the basis of race to the U.S. Equal Employment Opportunity Commission. The complainant further alleged that AHCA's interview process and posting of jobs was tainted and favored white candidates.

Although the complainant chose not participate in the AHCA OIG's investigation, the AHCA OIG was delivered sufficient evidence to support that the complainant was a member of a protected class and that they were subjected to an adverse employment action when they were not hired by AHCA. However, the AHCA OIG's investigation failed to disclose evidence to support the complainant's allegation that they were subjected to discrimination based on race when they were not selected for multiple positions at AHCA.

AHCA OIG #16-03-001

This investigation was initiated when AHCA's Bureau of Financial Services (BFS) informed the AHCA OIG that they found deficiencies in an AHCA employee's travel documentation submitted in association with trips made by the employee. According to BFS, the AHCA employee's reimbursement requests and AHCA Trip Logs did not indicate "work related travel corresponding to the P-Card rental charges" during a period for which the employee listed work related travel.

The AHCA OIG's review of documentary and testimonial evidence associated with the AHCA employee's travel documentation did not indicate that the employee used AHCA resources to rent cars for purposes other than AHCA work related trips or that the employee engaged in behavior that violated any statutes, rules, or AHCA policies.

## Internal Investigation Cases Index – FY 2015 -16

Case Number	Primary Allegation	Disposition	
1.	15-07-001	Facility Regulation	Referred
2.	15-07-002	Medicaid Fraud	Referred
3.	15-07-003	Discrimination	Unsubstantiated
4.	15-07-004	Unfair Employment Practices	Unsubstantiated
5.	15-07-005	Misuse of Resources	Referred
6.	15-07-006	Substandard Care	Referred
7.	15-07-007	Eligibility	No Action Taken
8.	15-07-008	Identity Theft	No Action Taken
9.	15-07-009	Medicaid Fraud	Referred
10.	15-07-010	Substandard Care	Referred
11.	15-07-011	Misuse of Resources	No Action Taken
12.	15-07-012	Other	IU Initiative
13.	15-08-001	Other	Referred
14.	15-08-002	Facility Regulation	Referred
15.	15-08-003	Conduct Unbecoming	Unsubstantiated
16.	15-08-004	Other	Referred
17.	15-08-005	Other	Information Only
18.	15-08-006	Other	Referred
19.	15-08-007	Medicaid Fraud	Referred
20.	15-08-008	Other	Information Only
21.	15-08-009	Substandard Care	Referred
22.	15-08-010	Medicaid Fraud	No Action Taken
23.	15-08-011	Medicaid Fraud	Referred
24.	15-08-012	Substandard Care	Referred
25.	15-08-013	Misconduct	Unsubstantiated
26.	15-08-014	Other	Information Only
27.	15-08-015	Other	Substantiated
28.	15-08-016	Other	Unsubstantiated
29.	15-08-017	Other	Unsubstantiated
30.	15-08-018	Other	Unsubstantiated
31.	15-08-019	Discrimination	No Action Taken
32.	15-08-020	Eligibility	Referred
33.	15-09-001	Other	No Action Taken
34.	15-09-002	Substandard Care	No Action Taken
35.	15-09-003	Substandard Care	Referred
36.	15-09-004	Other	Referred
37.	15-09-005	Other	No Action Taken
38.	15-09-006	Other	Unsubstantiated
39.	15-09-007	Other	Unsubstantiated
40.	15-09-008	Other	Referred



Case Number		Primary Allegation	Disposition
41.	15-09-009	Other	Referred
42.	15-09-010	Other	Referred
43.	15-09-011	Other	Referred
44.	15-09-012	Substandard Care	Referred
45.	15-09-013	Stark Law Violation	Referred
46.	15-09-014	Retaliation	Referred
47.	15-09-015	Conduct Unbecoming	Referred
48.	15-09-016	Safety	Referred
49.	15-09-017	HIPAA Violation	Referred
50.	15-09-018	Conduct Unbecoming	Information Only
51.	15-09-019	Substandard Care	Referred
52.	15-09-020	Medicaid Fraud	Referred
53.	15-09-021	Medicaid Fraud	Referred
54.	15-09-022	Other	Information Only
55.	15-09-023	Substandard Care	Referred
56.	15-10-001	Misconduct	Referred
57.	15-10-002	Other	IU Initiative
58.	15-10-003	Medicaid Fraud	Referred
59.	15-10-004	Other	Referred
60.	15-10-005	Other	Referred
61.	15-10-006	Other	Referred
62.	15-10-007	Sexual Harassment	Unsubstantiated
63.	15-10-008	Harassment	No action taken
64.	15-10-009	Other	Referred
65.	15-10-010	Other	Referred
66.	15-10-011	Misconduct	Referred
67.	15-11-001	Other	Unfounded
68.	15-11-002	Substandard Care	Referred
69.	15-11-003	Medicaid Fraud	Referred
70.	15-11-004	Substandard Care	Referred
71.	15-11-005	Misconduct	No action taken
72.	15-11-006	Substandard Care	Referred
73.	15-11-007	Misuse of Resources	Unsubstantiated
74.	15-11-008	IU Initiative	IU Initiative
75.	15-11-009	Substandard Care	Referred
76.	15-11-010	Conduct Unbecoming	Referred
77.	15-11-011	Substandard Care	Referred
78.	15-11-012	Medicaid Fraud	No Action Taken
79.	15-11-013	Other	Referred
80.	15-11-014	Eligibility	Referred

Case Number		Primary Allegation	Disposition
81.	15-11-015	Other	No Action Taken
82.	15-11-016	Substandard Care	Referred
83.	15-11-017	Sexual Harassment	Unsubstantiated
84.	15-11-018	Other	No Action Taken
85.	15-11-019	Conduct Unbecoming	Referred
86.	15-11-020	Other	No Action Taken
87.	15-11-021	Other	Referred
88.	15-11-022	Other	No Action Taken
89.	15-11-023	Eligibility	Referred
90.	15-11-024	Forensic Analysis	Forensic Analysis
91.	15-11-025	Forensic Analysis	Forensic Analysis
92.	15-12-001	Misconduct	Substantiated
93.	15-12-002	Forensic Analysis	Forensic Analysis
94.	15-12-003	Fraud	Referred
95.	15-12-004	Fraud	Referred
96.	15-12-005	Other	Referred
97.	15-12-006	IU Initiative	IU Initiative
98.	15-12-007	Other	No Action Taken
99.	15-12-008	Investigative Assist	Referred
100.	15-12-009	Information Only	No Action Taken
101.	15-12-010	Other	Outside purview
102.	15-12-011	Identity Theft	No Action Taken
103.	15-12-012	Substandard Care	No Action Taken
104.	15-12-013	Misconduct	Unsubstantiated
105.	15-12-014	Information Only	No action taken
106.	15-12-015	Other	No Action Taken
107.	15-12-016	Fraud	No Action Taken
108.	15-12-017	Other	Referred
109.	15-12-018	Misuse of Resources	Unsubstantiated
110.	15-12-019	Substandard Care	Referred
111.	15-12-020	Other	No Action Taken
112.	16-01-001	Other	No Action Taken
113.	16-01-002	Other	No Action Taken
114.	16-01-003	Substandard Care	Referred
115.	16-01-004	Other	Referred
116.	16-01-005	Medicaid Fraud	Referred
117.	16-01-006	Other	No Action Taken
118.	16-01-007	Substandard Care	Referred
119.	16-01-008	Misconduct	Unsubstantiated
120.	16-01-009	Other	No Action Taken

Case Number	Primary Allegation	Disposition	
121.	16-01-010	Substandard Care	Referred
122.	16-01-011	Misuse of Resources	Unsubstantiated
123.	16-01-012	Misuse of Resources	No Action Taken
124.	16-02-001	Discrimination	Unsubstantiated
125.	16-02-002	Substandard Care	Referred
126.	16-02-003	Fraud	Referred
127.	16-02-004	Eligibility	Referred
128.	16-02-005	Other	No Action Taken
129.	16-02-006	Other	Referred
130.	16-02-007	Other	No Action Taken
131.	16-02-008	Other	Unsubstantiated
132.	16-02-009	Other	No Action Taken
133.	16-02-010	Substandard Care	No Action Taken
134.	16-02-011	Medicaid Fraud	Referred
135.	16-02-012	Retaliation	Unsubstantiated
136.	16-02-013	Medicaid Fraud	No Action Taken
137.	16-02-014	Eligibility	Referred
138.	16-02-015	Discrimination	No Action Taken
139.	16-02-016	Discrimination	No Action Taken
140.	16-02-017	Other	No Action Taken
141.	16-03-001	Misconduct	Unsubstantiated
142.	16-03-002	Stark Law Violation	No Action Taken
143.	16-03-003	Substandard Care	Referred
144.	16-03-004	Other	Outside purview
145.	16-03-005	Substandard Care	No Action Taken
146.	16-03-006	Substandard Care	Outside purview
147.	16-03-007	Substandard Care	No Action Taken
148.	16-03-008	Other	Referred
149.	16-03-009	Other	No Action Taken
150.	16-03-010	Substandard Care	Referred
151.	16-03-011	Medicaid Fraud	No Action Taken
152.	16-03-012	Other	No Action Taken
153.	16-03-013	Violation of Agency Policy	Unfounded
154.	16-03-014	Other	Referred
155.	16-04-001	Medicaid Fraud	Referred
156.	16-04-002	Other	Unfounded
157.	16-04-003	Other	Referred
158.	16-04-004	Conduct Unbecoming	Unsubstantiated
159.	16-04-005	Conduct Unbecoming	Open
160.	16-04-006	Conduct Unbecoming	Unsubstantiated

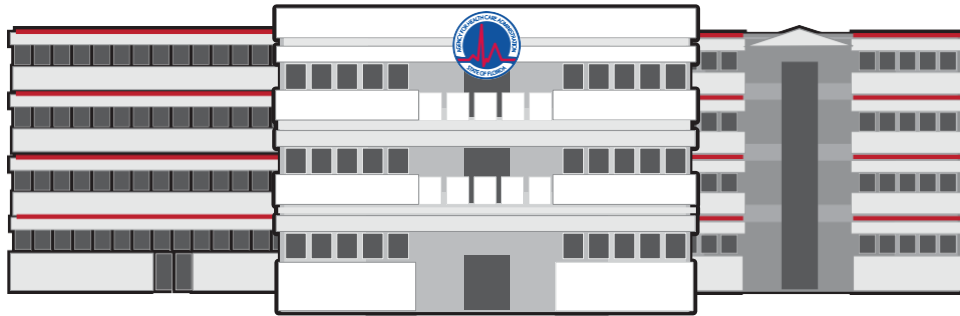
Case Number	Primary Allegation	Disposition	
161.	16-04-007	Other	No Action Taken
162.	16-04-008	Other	No Action Taken
163.	16-04-009	Medicaid Fraud	No Action Taken
164.	16-04-010	Other	No Action Taken
165.	16-04-011	Misconduct	Unfounded
166.	16-04-012	Conduct Unbecoming	Unsubstantiated
167.	16-04-013	Medicaid Fraud	No Action Taken
168.	16-04-014	Conduct Unbecoming	Unsubstantiated
169.	16-04-015	Conduct Unbecoming	No Action Taken
170.	16-05-001	Other	No Action Taken
171.	16-05-002	Fraud	Referred
172.	16-05-003	Misuse of Resources	Unsubstantiated
173.	16-05-004	Substandard Care	No Action Taken
174.	16-05-005	Substandard Care	No Action Taken
175.	16-05-006	Retaliation	No Action Taken
176.	16-05-007	Discrimination	Referred
177.	16-05-008	Medicaid Fraud	Referred
178.	16-05-009	Other	Open
179.	16-05-010	Misuse of Resources	Forensic Analysis
180.	16-05-011	Identity Theft	No Action Taken
181.	16-05-012	Substandard Care	Referred
182.	16-05-013	Other	No Action Taken
183.	16-05-014	Other	No Action Taken
184.	16-05-015	Eligibility	No Action Taken
185.	16-05-016	Medicaid Fraud	No Action Taken
186.	16-05-017	Medicare Fraud	No Action Taken
187.	16-05-018	Substandard Care	Referred
188.	16-05-019	Fraud	No Action Taken
189.	16-06-001	Other	No Action Taken
190.	16-06-002	Public Safety	No Action Taken
191.	16-06-003	Medicaid Fraud	No Action Taken
192.	16-06-004	Information Only	Information Only
193.	16-06-005	Fraud	No Action Taken
194.	16-06-006	Other	Referred
195.	16-06-007	Substandard Care	Referred
196.	16-06-008	Eligibility	No Action Taken
197.	16-06-009	Theft	No Action Taken
198.	16-06-010	Fraud	Referred
199.	16-06-011	Substandard Care	No Action Taken
200.	16-06-012	Theft	Referred

## **OIG Full-Time Staffing** **Increases and Decreases from Prior Year**

Bureau or Division	Position Title	Position Number	Added, Removed or Reclassified
<b>HIPAA</b>	Audit Evaluation and Review Analyst	#00606	Added
<b>MPI</b>	Administrative Secretary	#55650	Removed
<b>MPI</b>	Registered Nursing Consultant	#63481	Removed

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